

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED MAR 11 1943

Registration District No. 179

Primary Registration District No. 5669

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Lincoln  
(b) City or town Rural Hawtpoint  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community In this Community  
years, months or days 35 yr

3. (a) PRINT FULL NAME CARRIE COLBERT

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Arthur Colbert 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased. Sept 6 1985  
(Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days 18  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Hawtpoint Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Henry Harbaum

13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Barber

15. Birthplace Lincoln Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Colbert

(b) Address Hawtpoint MO

17. (a) Burial (b) Date thereof Feb 23, 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hawtpoint Cem.

18. (a) Signature of funeral director W. J. Jackson

(b) Address Troy MO

19. (a) Feb. 27-43 (b) Mrs. J. Jackson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Feb day 14  
year 1943 hour 11 minute 10 A.M.

21. I hereby certify that I attended the deceased from Feb 11, 1943 to Feb 14, 1943

that I last saw her alive on Feb 14 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 6 days

Due to asthma

Due to \_\_\_\_\_

Other conditions Chronic nephritis advanced  
(Include pregnancy within 3 months of death)

Major findings: Chronic nephritis

Of operations ✓

Of autopsy ✓

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ✓

(b) Date of occurrence ✓

(c) Where did injury occur? ✓  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

While at work? ✓ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. J. Jackson (M. D. or other) \_\_\_\_\_

Address Troy MO Date signed 2/20/43

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Wayne McCoy*

Licensed Embalmer No.

*3586*

P. O. Address

*Troy Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6860

Registration District No. ....

Primary Registration District No. 5669

Registrar's No. ....

1. PLACE OF DEATH:

- (a) County: Lincoln  
(b) City or town: Rural  
(c) Name of hospital or institution: (If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Carrie Colbert

3. (b) If veteran, name war: 3. (c) Social Security No. ....

4. Sex: F 5. Color of race: 6. (a) Single, widowed, married, divorced: m

6. (b) Name of husband or wife: 6. (c) Age of husband or wife if alive: 15 years

7. Birth date of deceased: Sept 6 - 1903 (Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days 5 If less than one day min.

9. Birthplace: (City, town, or county) (State or foreign country)

10. Usual occupation: ...

11. Industry or business: ...

12. Name: ...

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name: ...

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant: ...

(b) Address: ...

17. (a) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation: ...

18. (a) Signature of funeral director: ...

(b) Address: ...

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State: Mo (b) County: Lincoln  
(c) City or town: Rural (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country: ...

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb day: 14 year: 1943 hour: minute: M.

21. I hereby certify that I attended the deceased from 19...; that I last saw him alive on 19...; and that death occurred on the date and hour stated above. Immediate cause of death: Pneumonia

Due to: LOBAR

Due to: ...

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations: 108

Of autopsy: ...

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): ...

(b) Date of occurrence: ...

(c) Where did injury occur? (City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)

While at work? (c) Means of injury: ...

23. Signature: (M. D. or other)

Address: Date signed: ...

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

Duration

10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

